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DISCLAIMER

No changes to the ASPE shall be made, except by the Bureau Executive Director, who will make such changes as might be required to address budget, policy, regulatory, or legislative mandates.

This Certificate of Coverage replaces all Certificates, if any, previously issued to Eligible Participants and Covered Persons.

The ASPE self-insurance program is funded by the United States Department of State through the Fulbright-Hays authorizing legislation. The payment of medical benefits is subject to the availability of appropriated funds at the time when the claim is filed.

United States Department of State

ASPE

Accident and Sickness Program for Exchanges

for participants in programs sponsored by the

Bureau of Educational and Cultural Affairs

Effective April 15, 2001

ASPE

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ASPE Overview

The United States Department of State (DOS) provides essential health coverage for Department-sponsored and funded exchange participants in a variety of exchange-of-persons programs under the DOS Accident and Sickness Program for Exchanges (ASPE). The ASPE is a self-funded program designed to pay the covered medical expenses for eligible participants enrolled in the program.

The ASPE is not an all-purpose health insurance; **it is subject to specific limitations spelled out in this brochure.** You should read this brochure carefully and become familiar both with coverage and with claims procedures. It is especially important to understand the exceptions to and limitations of coverage to avoid incurring personal liability for medical expenses. The brochure will also give you general information about health care. If you have specific questions about anything contained in this brochure, or about health care in your country of assignment, please contact your programming organization.

The ASPE is specifically designed to support the programmatic goals of DOS's exchanges; it is valid only when you are participating in a program funded or sponsored by DOS and while you are participating in an exchange activity **outside** your home country. Coverage under the ASPE is not intended to support an individual whose chronic or long-term illness precludes satisfactory completion of objectives outlined in DOS's authorizing legislation. This program is neither intended to replace insurance you may already have nor is it automatically convertible to coverage upon completion of the assignment.

The ASPE complies with the J visa regulations which govern incoming exchange participants. This Certificate of Coverage, when shown with a valid Identification Card, is evidence of coverage under the ASPE and of the associated benefits. Anything contained in this Certificate is subject to the provisions, definitions, and exceptions as outlined in the General Policy Statement. This document is on file with the Department and may be examined at any reasonable time.

Health Care Provision

What is a Preferred Provider Organization?

Your health plan includes a preferred provider organization (PPO). A PPO is a network of physicians, hospitals, and clinics who have entered into an agreement with USDOS to accept discounted fees for services they provide to USDOS participants.

Using a PPO provider saves you money because USDOS pays 100% of your charges (or up to the policy limit). In most cases if a provider is participating in the network, your payment will not be required at the time of service (except for the deductible) as the network bills directly to the insurance administrator.

Failure to use an available PPO provider in the network will result in your being responsible for charges over the usual and customary amount if charged by the provider. That means you will be responsible for payment at time of service and any balance billings.

USDOS uses the CCN network as the primary network and has arrangements with the MMP laboratory, Durable Medical Equipment, radiology network and the Up and Up facility network.

How do I locate a provider or facility in the network?

You can search the primary network directly from our web site at http://www.oasys.com/usdos. Simply click on the section titled Network Access. There is also a network access telephone number on your ID card (1.800.726.0766) that you can call directly to find a network provider in your area. Americans abroad should contact the local Fulbright Commission, Embassy, or Consulate for a list of health care providers.

What about a hospital emergency room?

Emergency care is extremely expensive and should only be used in the most critical of circumstances (life threatening situations, broken bones, uncontrollable bleeding, etc.). Use of an emergency room in a non-emergency situation could result in additional charges for which you will be held personally responsible.

Do You Want To Save Money On Prescriptions?

Go Generic! Are generic drugs as effective as brand name drugs? Almost always, the answer is yes. When you need a new prescription, ask your doctor whether a generic can be substituted for a brand name. If your doctor gives the "ok" for the generic substitute, generally the pharmacist will charge you a lesser amount for your prescription. Over several refills, the savings can really add up. If you're currently taking a brand name prescription, ask your doctor if a generic drug would work as well. If so, you can start saving money with your next refill.

Mail Service Pharmacy

Merck-Medco Rx Services provides a convenient way for you to have your medication delivered right to your home or office. Merck-Medco Rx Services should be the first choice for people on maintenance medications. These are medications taken on an ongoing basis such as high blood pressure, heart and diabetes medications. Getting prescriptions filled through the Mail Service Pharmacy offers added convenience and can save you money.

Within the United States, U.S. territories or protectorates new prescriptions are delivered directly to your home or office by First Class Mail or UPS within 10–14 days after the prescription(s) is received by Merck-Medco Rx Services. Refill prescriptions received by 12:00 noon are mailed out the same day. Participants can use the Mail Service Pharmacy overseas with a valid prescription from a U.S. licensed physician and with an APO/FPO address.

To obtain a Merck-Medco Rx Services enrollment kit, contact USDOS Customer Service at 1.800.229.8742 or call member services at 1.800.818.0093 or visit the web site at www.merckmedco.com.

Prescription Drug Program Exclusions

Any over-the-counter drug that can be bought without a prescription.

Therapeutic devices or appliances or other non-medical substances, regardless of their intended use.

Contraceptives and supplies related to birth control, injectable and implantable contraception.

Drugs used to deter smoking.

Anorexiants, anti-obesity drugs.

Any drug for cosmetic purposes, including, but not limited to, Rogaine and Retin A.

Any quantity of drugs dispensed which exceeds the supply and refill limits.

Any prescription or refill dispensed more than one year after the original prescription.

Prescriptions filled prior to the effective date or after the termination date of the member's coverage.

Drugs labeled "Caution-Limited by Federal Law to Investigational Use," drugs which are experimental or investigational in nature, or which are in connection with experimental or investigative services or supplies, including drugs requiring federal or other governmental agency approval not granted at the time they are prescribed.

Related services or supplies including, but not limited to, administration of high dose chemotherapy, radiation therapy, or any other form of therapy or immunosuppressive drugs are not covered when supported by transplant procedures.

Immunization agents

Unreceipted blood plasma or blood expanders

Plasma/blood products (evaluated case by case)

Fertility drugs

Fluoride preparations

AIDS-related drugs

Non-insulin syringes/needles

Vitamins, vitamin A derivatives

Human growth hormones

Anti-narcolepsy drugs

Anti-hyperkinesis (treatment for ADD)

Biological sera

Injectable forms of covered drugs

Multiple sclerosis agents such as Betaseron, Avonex, Copaxone

Insulin

Diabetic supplies

Glucagon (emergency kits for diabetics)

Impotency drugs such as Viagra, Caverject, Muse

Identification Card

As a USDOS member you will receive an identification card to be used as proof of health care coverage when you need medical services. Simply show your identification card to the hospital, physician, or provider at the time of service. You should carry your identification card with you at all times in case you need emergency treatment. The identification card also serves as a prescription drug card for use when filling prescriptions at all PAID Prescriptions network pharmacies.

The back of your identification card contains important information regarding procedures along with the address used to file claims with the PPO network.

Lost or misplaced cards can be replaced within 7 to 10 days by calling Customer Service at 1.800.229.8742.

Coordination Of Benefits

Most group health care programs, including this program, contain a Coordination of Benefits provision. This provision is used when you are eligible for payment of claims under more than one group health program.

Coordination of benefits assures that your covered expenses will be paid, but that the combined payments of all of the programs do not amount to more than the actual cost of your care. Coordination of benefits prevents duplicate payments and helps control the cost of health care coverage.

When you have health care coverage from two or more insurance carriers, coordination of benefits determines which carrier is the primary payer and must pay claims up to the Limit of its policy. The other insurer is then designated as the secondary payer and must pay any remaining amount covered by the plan.

If you have health care coverage other than this USDOS plan, follow the guidelines on this page to determine when claims should be submitted to USDOS as the primary payer.

Do You Have Other Insurance Coverage?

1st: Submit claims to other group carrier.
2nd: Submit remaining charges to the USDOS plan using the PPO address on the back of your identification card.

Are You Listed As A Dependent Under Another Health Care Plan?

1st: Submit your claims to your primary health care plan. Your USDOS ASPE plan is your secondary insurance.
2nd: Submit any remaining charges to USDOS ASPE plan using the PPO network address on the back of your identification card.

Prescription Drugs

Merck-Medco administers the PAID Prescriptions drug benefits. Prescription drugs must be obtained from a participating PAID Prescription pharmacy.

Prescription Drug Program

The USDOS health care plan provides a prescription drug program to be used in combination with your health care benefits. Merck-Medco and its subsidiary, PAID Prescriptions, have a local and chain pharmacy network that contracts with pharmacies nationwide. Your USDOS Identification card also serves as your prescription drug card.

How To Use Your Prescription Drug Card

Your prescription drug card will be accepted at pharmacies that are part of the PAID pharmacy provider network. Simply present your card to have your prescriptions filled at any one of the network pharmacies in your area. The pharmacy will then electronically transmit a claim for that medication and, within minutes, have approval for filling the prescription.

How To Find A Network Pharmacy

You'll find a participating network pharmacy close to your home or place of work. The PAID network includes over 53,000 pharmacy locations nationwide. A chain store listing is included below. To locate the pharmacy nearest you, call member services at 1.800.818.0093 or visit the web site at www.merckmedco.com.

What You Should Do If Your Pharmacy Is Not Part Of The Paid Prescription Network

PAID Prescriptions allows pharmacies that are not presently participating in their network to submit claims electronically. Ask your pharmacist to call PAID Prescriptions or their telecommunications switchboard for information on how to transmit claims to PAID. Once a claim has been received by PAID, a participating pharmacy agreement will automatically be sent to the pharmacy.

A list of national and regional chain drug providers is listed below.

A
A&A Drug
Alp Freddy's
A&P Pharmacies
Appletree Pharmacy
ABCO Pharmacies
Appalachian Reg Healthcare
ACME Pharmacies
Arbor Drugs
Alaco Discount Pharmacies

Arrow Prescription Centers
Albertson's Food & Drug
Aurora Pharmacies, Inc.
Allens Drugtown

B

Bartell Drug
Begely Drug, Inc.
Bel-Air Pharmacies
Better Drugs Southwest
Bi-Lo Pharmacies
Big B Discount Drugs
Big C Discount Drugs
Big Bear Pharmacies
Bigg's Pharmacies
Big V Supermarkets, Inc.
Bi-Mart Corporation
Bi-Rite Drug Store
Bon Secours Pharmacy
Brooks Drugs
Brooks Pharmacies
Brookshire Pharmacies
Bruno's Pharmacies
Bud's Price King, Inc.
Buehler Pharmacies
Buffalo Pharmacies
Buttrey Food & Drug
Buy-Wise Drugs

C

Caldor Pharmacies
Care Drug Centers
(Circle Drug)
Carle RX Express Pharmacy
Carr Gottstein Company
CBC Professional Pharmacy
Chateau Drug & Surgical
City Drug Stores, Inc.
City Market Pharmacies
CIM, Inc.
Clinic Pharmacy
Clover Pharmacies
Community Distributors, Inc.
Concord Drugs
Consumers Pharmacies
Copps Pharmacies
The Copps Corporation
Corner Drug Store
Country Boy Pharmacy
Covenant Retail Pharmacies
CRX Pharmacy
CRXS, Inc.
Cub Pharmacies
Cummingham Drugs
Cummings Pharmacies
CVS Pharmacies

D

D&S Drug Mart
D&W Pharmacies
Dahl's Pharmacies
Dane Drugs
Davidson Drugs, Inc.
Dayton Cub Food Pharmacy
Dean Retail Services, Inc.
Degen-Berglund Pharmacy
Delchamps, Inc.
Dick's Pharmacy
Dierbergs Pharmacies
Dillon Pharmacies
Discount Drug Mart
Discount Emporium, Inc.
Doc's Drugs
Dominick's Pharmacies
Downeast Pharmacy, Inc.
Drug Barn
Drug Emporium
Drug Fair
Drug Festival, Inc.
Drug Mart
Drug Town
Drug World
Duane Reade

E

Eagle Food Centers Pharmacy
Easter Family Center Pharmacy
Easter's
Eckerd Drugs
Edgehill Drugs, Inc.
Edwards Pharmacies
Ely Drugs, Inc,
Emerald Drug Stores
Emporium Stores, Inc.
Erickson Valu Drug, Inc.
Enloe Drugs, Inc.
Eureka Drug Store, Inc.

F

F&M Pharmacies
Familycare Network
Family Discount Drugs
Family Drug
Farmco Drug
Farmer Jack Pharmacies
Farm Fresh, Inc.
Fay's Pharmacies
FEDCO Drugs
Federal Discount Center
Felpausch Pharmacy
Finast Pharmacies
First National Supermarkets
Foodarama Supermarkets, Inc.
Foodmax Pharmacies
Food Fair Pharmacies
Food World
Four Star Drug
Freddy's
Fred Meyer Pharmacies
Fred's Pharmacies
Fruth Pharmacy, Inc.
Fry's Food & Drug
Furr's Supermarkets, Inc.

G

Gemmel Drug Co.
Gemmel Pharmacy Group, Inc.
Genovese Drug Store
Gerbes Pharmacies
Gessler Drug Company
Gerland's Pharmacy
Giant Pharmacies
Giant Discount Drug
Giant Eagle Pharmacies
Giant Food, Inc.
Gibson Discount Drug
Goldy's
Gollash Pharmacies
Gooding Pharmacy
Grand Union Pharmacies
Gresham Drugs

H

Haggen/Top Foods Pharmacy
Hannaford Bros. Co.
Happy Harry's Discount Drugs
Harco Super Drug
Harris Teeter Pharmacies
Hartig Drug Company
Harts Pharmacies
Harvest Foods Pharmacies
Health Mart
Healthtek Pharmacies
Heartland Healthcare Services
H.E.B. Pharmacies
Hill's Family Drug
Hi-School Pharmacies
HMI Illinois, Inc.
Homeland Stores, Inc.
Horizon Pharmacies
Hospital Discount Pharmacies
Hook Drug
Hyde Drug, Inc.
Hy-Vee Pharmacies

I
I Got It At Gary's
Ike's Pharmacies
J
Joel N' Jerry's Pharmacy
Jones Apothecary
K
K&B, Inc.
Kash'N Kary
Keltsch Pharmacies, Inc.
Kerr Drug
Kessel Pharmacies, Inc.
Keystone-Medicine Chest
King Kullen Pharmacy Corp.
King Soopers
Kinney Drug
Klinck Stores, Inc.
Klingensmith's Drug Stores
Knight Drugs, Inc.
Kohl's Drug Stores
Kopp Drug, Inc.
Kroger Food & Drug
Kurtz Pharmacy
L
Langer Pharmacy
Laverdieres Super Drug Stores
Legend Pharmacies
Les-On Drugs
Lewis Drugs, Inc.
Lincoln Discount Drugs
Longs Drug Stores
Low Cost Health Care, Inc.
L.S.P., Inc.
Lucas Pharmacy
M
Malone's Pharmacy
Mann Drug Distributors
Maple Drug Stores
Mark Glassman, Inc.
Marsh Drug Store
Mast Drug
Maxi Drug, Inc.
Maxor Pharmacies
May's Drug Stores
McKay Drugs
M-D Pharmacies
Medi-Save Pharmacies, Inc.
Medistat Pharmacy
Medicap Pharmacies, Inc.
Medic Discount Drug
Medicine Man, Inc.
Medicine Shoppe
Med-X Corporation
Medamarket Service Plus RX
Meijer Pharmacies
Merrill's Drug Centers
Minyard Food & Drug
Motor City Prescription Center
Mr. Discount Drugs, Inc.
N
National Superermarkets
National Markets
NCS Healthcare, Inc.
Northeast Pharmacy Service Network
Northwest Health Ventures, Inc.
O
Omnilink Financial Services
Olson's Food Stores, Inc.
Osborn Drugs
Osco Drug, Inc.
Otto Drug
Ouy's Drug Store
Owl Drug Stores, Inc.
P
Parkway Drugs
Pamida Pharmacies
Pathmark Pharmacies
Pay-N-Save, Inc.
Pay-Less Drug Store
PDC, Inc.
Penn Traffic Company
Peoples Drug Store
Peterson Drug Company
Pharmacy Associates, Ltd.
Pharmacy Plus, Inc.
Pharmhouse Pharmacy Office
Phar-Mor, Inc.
Pic 'n Save Drug Company
Piggly Wiggly Pharmacies
A.L. Price Pharmacies
Price Costo Pharmacies
Price Chopper Pharmacy
Professional Pharmacy Services
Proxymed Pharmacy
Publix Pharmacy
Purity Supreme Pharmacies
Q
QFC (Quality Food Centers)
Quantum Health Resources
Quickcheck Food & Pharmacy
R
Raley's Drug Center
Randall's Pharmacy
Red Food Stores, Inc.
Reliable Drugs
REVCO D.S., Inc.
Rhinderer's Drug Stores, Inc.
Richardson Pharmacy
Rini-Rego Supermarkets, Inc.
Risch Drug Stores
Rite Aid Corporation
Ritzman Pharmacies, Inc.
RJR Drug Distributors
Rockbottom
Roeschen's Healthcare Corp.
Ronetco, Inc.
Rosauer's Pharmacy
RX Plus
S
Safeway, Inc.
Sav-a-Lot Drugs
SAVCO Drugs
Save-Mart Supermarkets
Sav-Mor Drug
Sav-On Drugs, Inc,
Sav-Rx Pharmacies
Schnuck's Pharmacies
Schewgmann Pharmacy
Scolari's Food & Drug, Co.
Scottie Pharmacies
Seaway Food Town, Inc.
Sedano's Discount Pharmacy
Sentry Drugs
Shelly's Pharmacy
Shopko Stores, Inc.
Shoprite Pharmacies
Sieps RX, Inc.
Skagway Pharmacies
Smith's Food and Drug
Smitty's Pharmacy
Snyder Drug Stores
Southeast Preferred Pharmacy
Standard Drug Company
Star Markets Co., Inc.
Stop & Shop Supermarket
Sunshine Drugs
Super 1 Pharmacies
Super D Drugs, Inc.
Super Food Barn Disc. Pharmacy
Super Fresh Pharmacies
Supermarkets of Cherry Hill
Super Sav-on Drugs
SuperValu
Super X Drugs
T
Target Stores
Thrift Drug, Inc.
Thriftway Food and Drug
Thrifty Drug
Thrifty PayLess
Thrifty White Drug
Times Pharmacy
Tom Thumb-Page Drug

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Tops Markets
Town & Country Drug
True Quality Pharmacies, Inc.
Twin Knolls Pharmacy
Twin Valu

U

Ukrop's Super Markets, Inc.
United Supermarkets
USA Drug & Beauty Market

V

Valco Drug Store
Valu Merchandisers
Village Supermarkets, Inc.
VIX Pharmacies
Vons Food & Drug
The Vons Companies, Inc.
Volunteer Drug Distributors

W

Wakenern Food/Shoprite
Wal-Mart Stores
Waldbaum's
Walgreen Company
Warehouse Markets, Inc.
Weathermax Drug Store
Wegmans Food Market
Weis Pharmacies
Wender & Roberts, Inc.
Wendt Briskol Company
Western Drugs
West Florida Pharmacies
White Front
White Shield Pharmacies
Winn-Dixie
WW Pharmacy, Inc.

Y

Youngfellow Pharmacy

Z

Zollie Supermarkets, Inc.

What should I take with me to the doctor or pharmacy?

When you seek medical treatment, take your valid ASPE identification card and a photo identification (such as a passport or university identification card). If you are seeing a provider outside of the network you should also take a claim form, as payment may be required at the time of service. It is also helpful to bring this brochure with you to show your provider what treatments are covered under ASPE.

Why should I carry my I.D. card with me?

Some health care providers require proof of insurance before they will provide health care services. Your card is proof of coverage under the ASPE. It contains important provider network logos needed to ensure you are not billed for amounts over usual and customary paid by your insurance. Also, if your medical condition prevents communication, the card gives health care providers valuable information.

A valid ASPE identification card may be used only by an eligible participant and must be filled out in its entirety, including complete name of the Covered Person, DOS program, program agent name, organizational affiliation, telephone number and dates of coverage. A person who does not meet eligibility requirements, or an individual seeking treatment outside the enrollment period, abrogates the Agency from any liability associated with loss or claim.

What should I do if I need medical attention which isn't available in my country of assignment? What if my doctor tells me I must go home immediately?

If your health condition requires that you receive medical treatment outside of the country of assignment, contact your program sponsor immediately. Detailed instructions for a medical evacuation can be found on the inside of the back cover of this brochure.

The Administrator And Claims

What is the Administrator?

The Administrator is the organization that will process your medical claims. The current Administrator is Outsourced Administrative Systems, Inc. (OASYS). To limit personal liability, we encourage you to contact the Administrator before receiving medical treatment if you suspect that the treatment may not be covered under ASPE. This is particularly important in cases where extensive treatment is sought. This is called pre-authorization. You may also request an advance review of payments on an anticipated claim or an assignment of benefits.

What is a claim? Why is this necessary?

A claim is a written request for payment for medical services. Filing of the claim is necessary in order for the Administrator to pay for the services provided to you by the health care provider. There are usually three ways this may happen:

1. Network providers should accept the ASPE identification card and file the claim on your behalf. You will be required to pay the $25 deductible immediately or will be billed for the deductible.

2. Non-network providers may ask you to pay for medical services when they are provided. This is called fee-for-service health care. After you pay the health care provider, you can then file a claim for reimbursement of these costs with the Administrator. You will be reimbursed for all covered care less the $25 deductible (see What is a deductible?).

3. You may be billed for the services by the health care provider instead of paying for the services immediately. (You may be required to pay the $25 deductible when the services are rendered). You may pay the bills and then submit a claim to the Administrator for reimbursement, or you may submit the bills and a claim form to the Administrator and request via an assignment of benefits (see What is an "assignment of insurance benefits?") that the Administrator pay the provider directly.

What is a deductible?

A deductible is the amount of money you are expected to contribute for your medical treatment. You will not be reimbursed for the deductible. The ASPE requires that you pay the first $25 for medical services associated with each accident or sickness. If your bills are greater than $25, the ASPE will pay the excess cost for covered treatment.

What is an "assignment of insurance benefits"?

This is your signed authorization (on the claim form) for the Administrator to pay your health care provider directly. This is necessary if, as described in #3 above, you submit the bills to the Administrator to pay the health care provider for you or as in above, the health care provider submits the claim to the Administrator on your behalf. By completing the "assignment of insurance benefits" section of the claim form, you are assigning the benefits to the health care provider.

In all cases, you are responsible for completing a claim form and supplying the necessary documents. The "assignment of insurance benefits" should always be completed. Eligible benefits will be payable to a designated health care provider or reimbursed to the claimant as indicated on the claim form. You are responsible for all charges which are not covered under the ASPE, including the deductible.

Will the ASPE pay for everything?

No. The ASPE provides only limited coverage for accidents and sicknesses. Please refer to the schedule of benefits for more information about the coverage limitations. Read the "Limitation on Benefits" section of this booklet to learn what is not covered under the ASPE. We recommend that you consider purchasing additional insurance if you feel that this coverage does not meet your needs.

Expenses for health care vary greatly throughout the United States and among different medical providers within the same community. To make sense of this variation, Usual, Customary, and Reasonable charges (UCR) have been determined for each community. The ASPE pays only those UCR charges and will not pay the extra or higher costs that some medical providers may charge. Network providers have agreed to accept further discounted rates.

What is the basis for determining UCR?

- ***Usual:*** An amount a professional provider usually charges for a given service.
- ***Customary:*** An amount which falls within the range of charges for a given service billed by most professional providers in the same locality who have similar training and experience.
- ***Reasonable:*** An amount which is Usual and Customary or which would not be considered excessive in a particular case because of unusual circumstances.

It is best to ask the medical provider outside of the network (in advance of treatment) what the charges will be. You may then contact the Administrator to determine if the charges are within the established UCR charges. The Administrator reserves the right to determine the amount payable for any service or supply.

The Language In This Brochure Is Difficult To Understand. How Do I Find Out If The Treatment I Need Is Covered Under This Program?

You should contact your programming organization with any specific questions. If they are unable to answer your questions, contact the Administrator. The telephone numbers for the Administrator are located on the back of this brochure.

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How To File A Claim

If you are using a non-network provider and have paid for services at the time of treatment you will need to file the claim for reimbursement. Claim forms are available and can be downloaded from the OASYS web site at http://www.oasys.com

1. Complete Part A of the claim form (information about yourself). Ask the health care provider to complete Part B (diagnosis/treatment, etc.).

2. Sign the completed form. Each claim form must include the Covered Person's name, program, program agency, address, contact name, signatures of the covered person and the medical provider, a diagnosis, date of service, and the type of service provided. Incomplete claim forms cannot be processed. Be sure to indicate who should receive payment (assignment of insurance benefits). Double check that all parts of the claim form are complete. Incomplete forms will delay payment.

3. Make a photo copy of the completed claim form, any receipts and bills, and your ASPE identification card.

4. If you pay for the services yourself (or if the health care provider will bill you), send the original claim form, receipts and bills from the hospital, doctor, lab and/or druggist, and a copy of your ASPE identification card to the Administrator.

5. If the medical provider will file the claim on your behalf, please provide him/her with the necessary information and addresses. Ask for a copy of the claim form.

6. You should mail claim forms, bills, or statements to the ASPE Administrator only after your medical treatment is finished, unless the treatment will continue longer than 20 days after the accident or onset of sickness. In this case, your claims should be filed as you receive treatment. A written request for payment, (called a claim) must be received by the Administrator before any payment is made.

Once the claim has been filed, you may be billed by the medical provider for those costs not covered by the ASPE.

After I submit my claim, what happens next?

You should receive notification of receipt of a claim in 21 days. This notice will tell you if you must take further action and what action must be taken. If the claim is complete, payment should be made in about four weeks. If the claim form is incomplete, or if the Administrator needs more information from you, then submit the information as soon a possible. If the Administrator needs more information from your health care provider, you will have to wait until the information is received before payment is made.

If you have not received notification of receipt of your claim within 21 days, please contact the Administrator. You should keep copies of any claims you submit until you receive notification of receipt.

My health care provider is claiming that payment has not been received. What should I do?

Contact the Administrator immediately. The Administrator will tell you if the payment has been made and explain the reasons for any delay of payment.

What is Medical Data Authorization?

Your signature is required on each claim form in a section entitled "medical data authorization." Your signature grants the Administrator and DOS the right to request medical records associated with your claim. Medical records are often required to properly review a claim. If you refuse to sign this authorization, the Administrator reserves the right to deny your claim based on incomplete information.

When should I file my claim?

Claim forms and itemized statements must be submitted to the Administrator **within 90 days of the first treatment for an accident or sickness.** For prompt payment, you should submit the information as soon as possible. If it is not reasonably possible to provide this information within 90 days, you must provide evidence of why you were unable to file. Except in the absence of legal capacity of the claimant, **a claim will not be accepted** if the claim forms and itemized statements are furnished later than one year from the date of the original loss.

Other Insurance

I've read that medical coverage in the United States is expensive. Can I purchase more coverage? Can I purchase coverage for something excluded by the ASPE?

Yes. Participants are encouraged to purchase additional insurance for losses not covered under the ASPE. Participants may purchase additional insurance from any commercial insurance carrier, or may purchase commercial health and accident insurance through the Administrator. The coverage described below per-

tains to Administrator-supplied policies. The benefits and limitations of these policies are *similar* to those of the ASPE. For more information, contact the Administrator regarding the exact terms of these plans.

Supplementary Insurance: During the time period when the Covered Person is enrolled in the ASPE, as indicated by the dates on the valid identification card, such Covered Persons may purchase a supplementary $200,000 coverage from the Administrator. This policy extends loss coverage under ASPE to $250,000 per accident or sickness.

I plan on being in the country of assignment longer than the grant period. Can I purchase coverage for that period?

Yes. The policy is described below.

Extension of Term: Comparable commercial insurance may be purchased from the Administrator if the Covered Person wishes to: **a**. remain (*after grant period has expired*) in the country of assignment, up to a maximum of three months; **b**. purchase transitional coverage, up to a maximum of three months, for U.S. participants upon return to the U.S. immediately following a grant; or, **c**. travel for personal reasons outside the country of assignment and country of domicile, up to three months, during the course of the grant. This option does not include travel to one's own country.

What about coverage for my spouse and children?

Your spouse and dependents **are not covered under ASPE.** Due to the high cost of medical services in the United States, and because a serious accident or sickness could result in medical and surgical costs of many thousands of dollars, you are required to obtain medical insurance for all your dependents. This is mandatory for J-2 visa holders. As a courtesy, DOS makes a policy available for purchase through Speciality Risk International called "Liaison International." You may prefer to purchase insurance from another commercial insurance carrier. Ask your programming agency for a list of companies which provide insurance which complies with J-visa regulations. Enrollment in this or any commercial policy is your responsibility.

I have other insurance for myself. What should I do if I need medical treatment?

If you have coverage extended from your home country, or are covered by a mandatory health/accident insurance plan at your institution, or decided to purchase a primary insurance policy in addition to your ASPE coverage, submit claims for medical treatment to your other health coverage plan (your *primary carrier*) before submitting a claim to ASPE (*your secondary carrier*). If your insurance doesn't pay for the treatment, or if you don't get fully reimbursed, you may then file the claim with ASPE for any remaining charges. ASPE will often reimburse you for the deductible you must pay under your primary policy. It is essential that you identify the other insurance carrier on your ASPE claim form, so that the Administrator can work together with your other carrier to ensure that you are reimbursed properly.

I need extensive treatment. What should I do?

You should contact the Administrator if you need extensive medical treatment (surgery, extensive medical tests, etc.). This is especially important in cases where the treatment is likely to interfere with your program.

What if I get so sick that I can't complete my grant?

If DOS, in consultation with the Administrator and the programming organization, determines that you are unable to perform all objectives of the grant with reasonable accommodation—both in your country of assignment and your expected subsequent contribution in your home country—your grant status, visa status, and enrollment in the ASPE will be terminated. If this situation should arise, you will be sent home as soon as your physician indicates that your condition has stabilized and you can be released for travel.

If the seriousness of a covered Sickness or Injury results in a *medical determination* that you must be returned to your home country, the ASPE will terminate upon your arrival in that country. If the medical condition for which you were being treated requires further care, you may continue to submit claims to the Administrator for that condition. If your health permits you to return to the country of assignment and you resume your DOS program, the ASPE will be reinstated upon your departure from your home for the country of assignment.

Enrollment Period

When should I enroll?

The organization responsible for your DOS program will handle your enrollment in ASPE. They may enroll you prior to departure from your home country or they may ask you for information and enroll you upon arrival. You must be enrolled within 30 days of arrival in your country of assignment.

How do I know that I am enrolled?

Enrollment is evidenced by a valid ASPE identification card indicating the dates of coverage.

When does my coverage start?

In general, coverage begins at the time you depart from your home country and continues until you return to your home country. Please note that this travel benefit is only valid when you travel directly to and from the country of assignment—immediately prior to and after a DOS program. This includes coverage for any allowed layover of up to 24 hours if the travel time by the most direct route exceeds 14 hours.

I'm going to spend five days in Paris on the way to my program. Will I be covered during this stopover?

No. If you choose to vacation en route, your coverage will begin upon arrival in the country of assignment.

I will be arriving in my country of assignment early to travel and find housing. Will I be covered during that time?

No. Unless your program specifically calls for additional time in-country, you are covered only during the authorized dates of the program. You may elect to purchase traveler's insurance for the extra time in-country.

I will be conducting academic research—related to my grant—in a third country during my University's summer break. Will I be covered during this break?

No. Your coverage will end the day you leave your country of assignment and will be reinstated when you return from your third country travel, *unless* the travel is in your original grant and/or research design, or you have prior authorization from DOS to travel to a third country for research purposes.

I have an orientation in my home country. Will I be covered during the orientation?

Yes. However, ASPE will be valid only if you must travel to another city in your country and you are enroute to your overseas assignment.

I'm confused. My situation is different. Where can I get this explained better?

The coverage dates are explained in detail in the General Policy Statement which governs the ASPE. This can be requested at any time from DOS. Alternatively, you may ask your programming organization to explain the terms of the program to you.

What is Covered

I have heard that dental care in the U.S. is great. Can I get dental work done while I'm in the U.S.?

The ASPE does not cover dental treatment unless it is directly related to a covered injury or accident, or if you are in extreme pain. You are welcome to seek dental care while in the U.S., but the ASPE will not cover those expenses.

I have had heart disease for years. What happens if I have a heart attack while on a DOS program?

The ASPE will not pay benefits related to a pre-existing condition. Because you will be personally responsible for all expenses related to any pre-existing condition, carefully consider the financial risk that pre-existing conditions may pose.

I need new glasses. Will the ASPE cover my eye exam and glasses?

No. ASPE does not cover expenses for routine eye care or corrective lenses.

I've heard that DOS sends participants home if they seek mental health care. Is this true?

No. Decisions about termination of programs are made on a case-by-case basis in accordance with the terms of the grant, and are not based on the cost or nature of medical claims. The Administrator notifies DOS when it receives five claims for mental health benefits, if claims for other benefits become substantial, or if the diagnosis suggests a problem which places the program at risk. After notification, the DOS program officer will monitor the situation to ensure that the participant is able to successfully fulfill the terms of the grant.

Please read the "Schedule of Benefits" and "Limitation on Benefits" sections for complete information on coverage.

Legal Rights and Responsibilities

If my claim is denied, can I appeal the decision?

Yes. If you feel that your claim was incorrectly denied, and that the loss is covered under the terms and conditions of the ASPE, you may appeal the decision. Please provide justification and the associated citation from this brochure (and/or medical opinion) which supports your appeal to the Administrator.

What is "right of recovery"?

If the Administrator has paid more than necessary, then the Administrator has the right to recover the amount overpaid. This could happen if the medical provider bills the Administrator more than once for the same procedure, or if the Administrator pays a claim and later discovers that another insurance has paid for the same claim. Please note that if the Administrator is unable to recover overpayments, it could affect your future benefits under the ASPE.

What if I am injured in a car accident or on the job?

If you are injured in an automobile accident or in some other situation in which another individual or organization is responsible for your injuries, that person's or organization's insurance is liable for your medical expenses. In such cases, it is important to tell the Administrator when you submit your claim that the claim is related to an on-the-job, automobile, or other accident in which a third party is liable for your injuries. The Administrator will contact you for information in an attempt to coordinate the benefits with the responsible insurance company.

Description of Coverage

All Covered Expenses incurred as a result of the same or related cause (including any complications) shall be considered as resulting from one Injury or Sickness. The amount payable for any one Injury or Sickness will not exceed the Maximum Benefit limit shown on the Schedule of Benefits and is subject to the following provisions:

1. the deductible amount must be paid by the Covered Person;
2. the expenses must have been incurred within one calendar year of the date of Injury or commencement of Sickness;
3. the Covered Person must have remained continuously insured under the ASPE;
4. the Sickness or Injury must have occurred in the country of assignment;
5. all other limitations, exclusions and terms of the ASPE.

If a Covered Person incurs expenses due to an Injury or a Sickness (as defined in this Program), benefits will be payable for the Usual, Customary and Reasonable Charges (UCR) for the Covered Expenses listed below which are incurred in connection with that Injury or Sickness.

The Department will pay 100% of all Covered Expenses listed below, which are in excess of the Deductible Amount shown in the Schedule of Benefits.

Basic Medical Expenses:

Maximum Benefit Per Injury or Sickness	$50,000.00
Deductible Amount Per Injury or Sickness	$25.00

Medical Evacuation (Medevac):

Actual Cost for Approved Benefits	No limit
Deductible Amount per Medical Evacuation	$0.00

Repatriation of Remains:

Maximum limit	$7,500.00
Deductible Amount	$0.00

Treatment for an Injury or Sickness is covered up to one calendar year from the date of onset.

Covered Expenses

Covered Expenses with respect to the ASPE are limited to the following Usual, Reasonable and Customary charges:

1. Fees for diagnosis and treatment by a physician, surgeon, registered nurse, professional anesthetist, or radiologist, including physical therapy related to a covered Injury.

2. Hospital room and board charges. Payment will be limited to the Hospital's normal charge for semi-private accommodation. *Please note: The cost of telephone service, television rental and other similar services of a personal nature are* ***not*** *covered under the ASPE.*

3. Laboratory, diagnostic and X-ray examinations.

4. Drugs and medicines for Outpatient treatment which require a Physician's written prescription, and which can only be dispensed by a licensed pharmacist.

5. Rental charge for Durable Medical Equipment, or the purchase of this equipment, whichever is less.

6. Professional ambulance service.

7. During the period of an individual's participation in a Department funded exchange activity, the ASPE will cover medical expenses for maternity care—including childbirth during this period. Maternity benefits end at the end of the enrollment period regardless of other conditions of this policy. In addition to the medical expenses of maternity care required by the participant herself, the medical expenses of the child newly born to her during the grant period are covered to the $50,000 limit for the newborn's first 31 days. For coverage beyond the 31 day period, a participant must obtain commercial insurance coverage for the newborn dependent at personal expense. The ASPE does not pay the expenses of a child newly born to a dependent of a participant. The participant is advised to obtain commercial insurance for the maternity care of the dependent which will cover the newborn.

8. This program will pay the actual expense incurred as a result of a covered Injury or Sickness for medical evacuation of the Covered Person, including physician or nurse accompaniment to the nearest suitable medical facility. For Americans abroad, medical evacuation expenses will be paid only upon written certification by an embassy-approved medical authority that appropriate medical care is not available at the place of assignment. Expenses associated with medical evacuation require prior approval of the Department or embassy official. Evacuation costs will be paid directly by the Department; associated medical expenses will be paid by the Administrator.

9. Expenses incurred for treatment of nervous or mental disorders. The Department shall not be liable for more than one such Inpatient or Outpatient occurrence per lifetime under this Program with respect to any one Covered Person.
Treatment of Mental and Nervous condition is payable subject to the following schedule:

Inpatient Care: Maximum 30 days of hospital confinement
Outpatient Care: Up to $75 per visit to a maximum benefit of twenty visits subject to the deductible per illness outlined in the schedule of benefits

The Third Party Administrator will notify DOS when it receives claims for more than five visits for any one Covered Person.

10. In the event of a Covered Person's death, the Department will pay for actual charges incurred up to the Maximum limit shown on the Schedule of Benefits in connection with the preparation and transportation of the body to the person's place of residence in his or her home country. This benefit does not include the transportation expense of anyone accompanying the body.

11. Physical Therapy medically prescribed and directly related to the complications associated with an Injury or Sickness incurred during the period of coverage.

Deductible Amount: The deductible is the dollar amount of Covered Expenses which must be incurred as an out-of-pocket expense by each Covered Person on a per Injury or Sickness basis before certain benefits are payable under the ASPE. The Basic Medical Expense Deductible Amount is shown in the Schedule of Benefits.

Limitation on Benefits

The Bureau's Accident and Sickness Program does not cover the following:

1. Benefits for loss due to a pre-existing condition. A pre-existing condition is any condition which
- **a.** existed prior to the Covered Person's effective date of coverage, with or without his/her knowledge;
- **b.** a Physician was consulted prior to the Covered Person's effective date of coverage;

SCHEDULE • OF • BENEFITS

c. treatment or medication was received prior to the Covered Person's effective date of coverage; or
d. would have caused any prudent person to seek medical advice or treatment prior to the Covered Person's effective date of coverage.

Participants are urged to retain or obtain their own insurance to cover ongoing or potential medical requirements relating to pre-existing conditions.

NOTE: *For purposes of the ASPE, pregnancy is not defined as a pre-existing condition.*

2. Spouse and Dependents. Coverage for accompanying spouse and dependent children may be purchased by the participant through the DOS claims administrator or other commercial insurance agent.

3. Expenses incurred for the treatment of an Injury or Sickness more than one calendar year after the time of the Injury or onset of the Sickness.

4. Expenses incurred within the Covered Person's home country or country of regular domicile, unless:
a. it is *necessary* and *authorized* treatment received after the individual has proven Sickness or Injury in the country of assignment; or
b. it is related to a pre-approved medevac and which would have otherwise been covered had the expenses occurred in the country of assignment.

5. Services or supplies for any Injury or Sickness received prior to the Covered Person's effective date under the ASPE, or which are not actually incurred while this Program is in force.

6. Injury or Sickness sustained or contracted during any period of unofficial travel outside the country of assignment.

7. Expenses covered under any occupational benefit plan, Workers Compensation Act or similar law, automobile medical payment or no-fault plans, public assistance programs, government plan, any other valid and collectible group insurance, or any primary insurance. However, the ASPE will pay medical expenses which are not paid by such primary insurance due to application of deductibles or limitations on benefits, provided that such expenses would otherwise be covered by the provisions of this Program.

8. Expenses in excess of Usual, Customary and Reasonable Charges.

9. Services or supplies which are experimental or investigative in nature; including any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not recognized as accepted medical practice; and any such items requiring federal or other governmental agency approval not received at the time services were rendered.

10. Charges of an institution, health service, or infirmary which does not require payment in the absence of insurance.

11. Professional services rendered by a member of the Covered Person's immediate family or anyone who lives with the Covered Person.

12. Expenses incurred during a hospital emergency room visit which is not of an emergency nature.

NOTE: *Emergency nature is defined as that treatment sought under life-threatening circumstances and for a condition that could not be left unattended without causing further injury or complications.*

13. Routine physical examinations or health examinations including routine care of a newborn infant. "Routine exams" include vaccinations, immunizations, and any such exam required for registration at a university. The program does not cover maternity medical care before or after the period of assignment.

14. Expenses incurred resulting from the use of alcohol or intoxicants, or any drugs by the Covered Person, unless prescribed by a Physician; expenses incurred due to substance abuse treatment.

15. Treatment to the teeth, gums, jaw, or structures directly supporting the teeth. This exclusion does not apply to the repair of injuries to sound natural or false teeth caused by a covered Injury including surgical extractions of teeth. This exclusion does not apply to treatment for the emergency alleviation of pain, in which case dental treatment shall be limited to $500. The Administrator may reject any claim for dental treatment when not accompanied by proof of a covered Injury to the participant. Pyorrhea is a disease and is covered as a medical expense.

16. Services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a covered Injury.

17. Treatment of congenital anomalies and conditions arising or resulting directly therefrom.

18. Expenses incurred for plastic or cosmetic surgery, unless they result directly from a covered Injury which necessitated medical treatment within 24 hours of the accident.

19. Expenses incurred for services related to the diagnostic treatment of infertility or other problems related to the inability to conceive a child, unless such infertility is a result of a covered Injury or Sickness.

20. Birth control, including surgical procedures and devices, and elective termination of pregnancy.

21. Deviated nasal septum, including submucous resection and surgical correction thereof.

22. Expenses incurred in connection with weak, strained or flat feet, corns, calluses, or toenails.

23. The diagnosis and treatment of acne.

24. Expenses incurred for chiropractic care, which is defined as outpatient treatment in connection with the detection or correction by mechanical or manual means of structural imbalance, distortion or subluxation on the human body for the purposes of removing nerve interference as a result of or related to distortion, misalignment, or subluxations of or in the vertebrae column.

25. Services and supplies not medically necessary for the diagnosis or treatment of a covered Sickness or Injury; or which are not recommended by the attending Physician, including television and telephone access while hospitalized.

26. Loss due to war, declared or undeclared, while in the service in the Armed Forces of any country.

27. Intentionally self-inflicted injury; suicide, or any attempted threat.

28. Losses resulting from Perilous Activity.

29. Expense incurred for taxicabs or other transportation to and from the doctor's office or other place of treatment, except if an approved medical evacuation expense.

Claims Appeal

If a claim for benefits under this ASPE program is totally or partially denied, the Covered Person has the right to appeal.

An appeal of a denied claim must be made in writing and should include an explanation, written by the Covered Person, of why he or she thinks the claim should be paid. The Covered Person should submit any additional information he or she believes will be helpful in the review of the appeal.

To receive consideration, the Covered Person must ***present the request for a review to the Administrator within 30 days of the denial of the original claim,*** or as soon thereafter as is feasible. The decision on an appeal will be made in writing within 60 days of receipt of the formal written request and will include the specific reasons for the decisions and reference to the relevant provisions of the ASPE involved in the case. Final decisions for appeals rest with the Department.

Assignment

The payment of medical benefits is subject to the availability of appropriated funds at the time when the claim is filed. An assignment of insurance benefits will be binding on the Department only after a copy of the assignment has been received by the Administrator. The Department will not be liable for an unauthorized assignment of insurance benefits. A Covered Person may request advance review of payments on an anticipated claim or an assignment of insurance benefits. Any payment of claims of eligible benefits made in good faith will relieve the Department of liability under the ASPE.

Legal Action

No action at law or in equity may be brought to recover on the ASPE prior to the expiration of 120 days after written claim form and other proof of loss as required have been furnished. No such action may be brought after the expiration of three years after the time written claim form and required proof of loss were to have been furnished.

Clerical Error

A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated.

Subrogation

If the Covered Person is injured or becomes ill through the act or commission of another person, and if benefits are paid under this plan due to that Injury or Sickness, then to the extent the Covered Person recovers for the same Injury or Sickness from a third party, its insurer, or the Covered Person's uninsured motorist insurance, the Department will be entitled to a refund from such recovery of all benefits it has paid.

The Department may file a lien in a Covered Person's action against the third party and have a lien upon any recovery that the Covered Person receives, whether a settlement, judgment, or otherwise, and regardless of how such funds are designated. The Department shall have a right to recovery of the full amount of benefits paid under this Program for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. The Department will not be responsible for the Covered Person's attorney's fees or other costs.

Upon request the Covered Person must complete the required forms and return them to the Administrator. The Covered Person must cooperate fully with the Administrator in asserting its right to recover. The Covered Person will be personally liable for reimbursement to the Agency to the extent of any recovery obtained by the Covered Person from any third party. If it is necessary for the Department to institute legal action against the Covered Person for failure to repay the ASPE, the Covered Person will be personally liable for all costs of collection including reasonable attorney's fees.

Right of Recovery

Whenever payments have been made by the Department with respect to benefits payable under this Program in excess of the amount necessary, the Department shall have the right to recover such overpayments. The Department shall notify the Covered Person of such overpayment and request reimbursement from the medical provider. However, should the medical provider not provide such reimbursement, the Department has the right to offset such overpayment against any other benefits payable to the Covered Person under this Program to the extent of the overpayment.

Unless specifically described elsewhere in this document, the terms below are defined as follows:

Administrator – A private company contracted by the Department of State to administer the health coverage program. The current administrator is OASYS (Outsourced Administrative Systems, Inc. of Indianapolis, IN).

Ambulatory Surgical Facility – An establishment which may or may not be part of a Hospital and which meets the following requirements:

- **a.** it is in compliance with the license or other legal requirements in the jurisdiction where it is located;
- **b.** it is primarily engaged in performing surgery on its premises;
- **c.** it has a licensed medical staff, including Physicians and Registered Nurses;
- **d.** it has permanent operating room(s), recovery room(s) and equipment for emergency care; and
- **e.** it has an agreement with a Hospital for immediate acceptance of patients who require Hospital care following treatment in the ambulatory surgical facility.

Appeal – When an ASPE claim has been denied, a grantee has the right to appeal the decision. He or she must submit detailed justification, supported by pertinent documentation to the Administrator for review.

ASPE – Accident and Sickness Program for Exchanges, the self-insurance program offered to U.S. Department of State exchange program participants administered by OASYS.

Assignment of insurance benefits – A section on the ASPE claim form that, when signed and dated by the grantee, authorizes the Administrator to make payments directly to the health care provider.

Carrier, primary/secondary – Because a grantee should have his or her own insurance provider in addition to ASPE, his or her principal insurance plan is referred to as the "primary carrier" and ASPE would be considered the "secondary carrier." A grantee who has a primary and secondary carrier would first submit claims to the primary carrier and then to the secondary carrier.

Certificate of Coverage – Document which explains the benefits, limitations, exclusions, terms and conditions of your health coverage.

Certificate of Creditable Coverage – Provides evidence of your prior health coverage. Certificate of Creditable Coverage is provided upon request. (1.800.299.8742)

Claim/claim form – A written request for payment for medical services. Claims are submitted along with receipts and any other relevant documentation to OASYS only after treatment has been received. Claim forms are available at the OASYS web site at www.oasys.com/usdos.

Complications – A secondary condition, either Injury or Sickness, that develops or is in conjunction with an already existing Injury or Sickness.

Complications of Pregnancy – Any medical condition which is a distinct complication from a normal pregnancy but which is adversely affected by or caused by pregnancy. It includes: acute nephritis, nephrosis, cardiac decompensation, missed abortion, a medically necessary caesarean section, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy occurring when a viable birth is not possible, and similar serious adverse medical conditions caused by or affected by pregnancy. "Complications of Pregnancy" does not include: false labor, occasional spotting, Physician prescribed rest during pregnancy, morning sickness, preeclampsia, and conditions involved in a difficult pregnancy not medically classified as a distinct complication of pregnancy.

Cooperating agency – An organization that has been awarded a Department of State grant to administer one or more of the various exchange programs.

Coordination of Benefits – When a grantee has more than one health insurance carrier, the benefits derived from each must be coordinated so as to assure that the combined payments do not amount to more than the actual cost of the health care received.

Covered Expenses – For the purposes of these benefits, expenses actually incurred by or on behalf of a Covered Person for those services and supplies which are:

- **a.** administered or ordered by a Physician;
- **b.** medically necessary to the diagnosis and treatment of an Injury or Sickness; and
- **c.** are not excluded by any provision of the ASPE. A Covered Expense is deemed to be incurred on such date such service or supply which gave rise to the expense or charge was rendered or obtained.

Covered Person – A participant in an eligible Department-sponsored exchange program who is enrolled in the ASPE. "Eligible program" does not include those for which Department support is primarily for administrative or facilitative support rather than direct participant costs. "Participants" does not include escorts, escort/interpreters, staff of organizations receiving grant support directly or indirectly from the Department, independent consultants associated with these organizations, or dependents of program participants.

Deductible – An amount of money that is not covered by ASPE or other health coverage for a specific medical treatment and for which the grantee is responsible for paying. The deductible for ASPE is $25 per accident or sickness.

Department – The United States Department of State.

Durable Medical Equipment – Medical equipment which:

- **a.** is prescribed by the Physician who documents the necessity for the item including the expected duration of its use;
- **b.** can withstand long-term repeated use without replacement;
- **c.** is not useful in the absence of Injury or Sickness; and
- **d.** can be used in the home without medical supervision.

The ASPE will cover charges for the purchase of such equipment when the purchase price is expected to be less costly than rental.

Eligible Participant – See "Covered Person" definition above.

Emergency – A sudden, unexpected onset of a medical condition that, in the reasonable opinion of the Covered Person, is of such a nature that failure to receive immediate care by a licensed medical provider would place the Covered Person's life in danger, result in the loss of life or limb, or cause serious impairment to the Covered Person's health.

Enrollment – Grantees are eligible to participate in ASPE when they are registered or enrolled in the program by their commission or cooperating agency. The commission or cooperating agency issues each grantee an ASPE identification card.

Fee-for-service health care – The patient is required to pay for the medical service at the time it is received. Except for treatment sought through the PPO available through ASPE, or if the health care provider files a claim on the grantee's behalf, grantees must pay for treatment and submit claim forms, receipts and all other relevant documentation to OASYS.

Health Care Provider – Any doctor, hospital, or clinic that provides medical services.

Hospital – An institution which:

a. operates as a Hospital pursuant to law for the care and treatment of sick or injured persons as inpatients;
b. provides 24-hour nursing service by registered nurses on duty or call;
c. has a staff of one or more Physicians available at all times;
d. provides organized facilities for diagnosis, treatment and surgery either on its premises, or in facilities available to it, on a pre-arranged basis; and
e. is not primarily a nursing, rest convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such.

Injury – An accidental bodily Injury sustained by a Covered Person while covered under the ASPE and occurs independent of all other causes.

Inpatient – A person who is a resident patient, using and being charged for the room and board in a Hospital.

Intensive Care Facility – An intensive care unit, cardiac care unit or other unit or area of a Hospital:

a. which is reserved for the critically ill requiring close observation; and
b. which is equipped to provide specialized care by trained and qualified personnel and special equipment and supplies on a standby basis.

Loss – The financial loss associated with an accident or sickness for which a claim is submitted to the Administrator.

Medevac – Medical Evacuation. A medical situation, either emergency or non-emergency, for which a grantee must be sent to another location in order to receive appropriate medical attention.

Medical Data Authorization – The section of the claim form that, when signed and dated by the grantee, allows the health care provider to submit to the Administrator any medical records pertinent to a given claim.

Mental or Nervous Disorder – Neurosis, psychoneurosis, psychosis, or mental or nervous disease or disorder of any kind.

OASYS – Outsourced Administrative Systems, Inc. A private company contracted by the U.S. Department of State to administer the ASPE program.

Outpatient – A person who receives medical services and treatment on an Outpatient basis in a Hospital, Physician's office, Ambulatory Surgical Center, or similar centers, and who is not charged room and board for such services.

PAID Perscriptions – The retail pharmacy network.

Perilous Activity means:

a. Flying, except as a passenger:
- on a regularly scheduled airline;
- on a chartered carrier for purposes of an approved grant program activity;
- in the Military Airlift Command of the U.S. or similar air transport services of other countries.

b. Playing, practicing, or participating in intercollegiate, club (professionally organized) or professional sports, or during travel for such purposes.
c. Operation of a vehicle while not properly licensed to do so or riding in a non-commercial vehicle operated by a person not licensed to do so in the jurisdiction in which the accident takes place.
d. Dangerous activity not directly related to the fulfillment of grant objectives, *e.g.* bungee jumping, scuba diving, sky diving and rock climbing.

Physician – A qualified, licensed health care practitioner, acting within the scope of his or her license who is not the Covered Person or a member of his or her immediate family.

Physiotherapy – A physical or mechanical therapy, diathermy, ultrasonic, heat treatment in any form, manipulation, or massage.

Pre-authorization – For extensive medical treatment, grantees must contact OASYS prior to seeking treatment to assure that the claim will be honored by ASPE.

PPO – Preferred Provider Organization. A network of physicians, hospitals, and clinics in the U.S. who have entered into an agreement with the USDOS to accept discounted fees for services they provide to USDOS exchange program participants.

Registered Nurse – A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters R.N. after his or her name.

Right of recovery – When payments for a given medical treatment have been made in excess of the amount necessary, the Department of State has the right to recover such overpayments. The DOS will notify the grantee of the overpayment and request reimbursement from the health care provider. If the health care provider does not reimburse DOS for the overpayment, DOS reserves the right to offset the overpayment against any other benefits payable to the grantee.

Sickness – An illness, disease, or physical condition of a Covered Person commencing while coverage is in force as to the Covered Person.

UCR – Usual, customary, and reasonable. Criteria established and used by the Administrator to determine the amount payable for a given service or supply.

If this is a life-threatening medical emergency:

- In the United States, dial 911 from any telephone. You will be connected to a special emergency operator. This person will assist you in obtaining an ambulance. Do not use 911 unless the situation is an emergency as defined on page 33.
- If you are outside the United States, contact the U.S. embassy or Consulate, the Fulbright Commission, or your programming organization for information about emergency help.

If you need medical attention for an injury or sickness:

- Find a medical provider—a local physician, an urgent care clinic, student health center. For very serious conditions, seek treatment in a hospital emergency room (other options should be sought if the condition is not an emergency). Americans abroad should consult the U.S. Embassy or Consulate for a list of recommended health care providers in the area of assignment.
- Present your ASPE identification card, a photo-identification, a claim form as well as this brochure to the medical provider.
- Ask what the charges may be for the services needed. ASPE will not pay for any expenses in excess of the UCR charges for the treatment required. Be sure to ask the doctor or hospital if the ASPE program payment will be accepted as "assignment of fees paid in full" or if you will be required to pay for services rendered (either immediately or by a bill) in which case you will be reimbursed for covered expenses from ASPE.
- In cases of major treatment, obtain pre-authorization from the Administrator. Remember, it is a good idea to contact the organization responsible for administering your program.
- Complete the claim form, make photo copies of the information and send the originals to the Administrator.
- If you have questions about your coverage, contact the organization implementing your program or another responsible party (e.g., Foreign Student Advisor, escort/interpreter, DOS officer, U.S. embassy official).

If you need to be medically evacuated out of your country of assignment:

For Americans Abroad:

- Contact the U.S. Embassy, Consulate or post.
- Explain your need for medical care and why it cannot be provided at your place of assignment.
- If the Embassy approved medical authority concurs that you must be evacuated, Embassy staff and/or programming staff will contact DOS to assist in transporting you to the closest, most suitable medical facility.
- In most cases, the Embassy will handle the filing of your evacuation bills; however, if you file, submit the bills along with a written authorizing statement from the Embassy-approved medical authority directly to DOS.

For foreign nationals in the U.S.:

- Contact the organization responsible for administering your program.
- Provide medical documentation that you are able to travel.
- The organization responsible for administering your program will contact DOS. DOS will make the necessary arrangements.

ASPE • NOTES